May 20, 2011

Re: Kaiser Permanente Insurance Co.

State Tracking Numbers: PF-2011-00828, PF-2011-00829

Mr. Shekhter:

We have reviewed your submission to SERFF with respect to Kaiser's recent small-group medical expense filings. To continue with our review of this filing, we require additional information and responses to the following questions. Your responses should be in Excel where appropriate. Please submit your replies through SERFF. We appreciate your cooperation in this matter.

1. **Product Descriptions.** Furnish descriptions of each product in these filings.

Response:
Please see the accompanying supporting document, "POS Response #1"..

2. **Changes to Benefits.** Describe in detail changes to benefits over the past 12 months, if any, indicating which of these are mandated, and the rate impact of each of those changes.

Response:

Please see the "Question 2" page in the accompanying document, "Jul-11 POS Data for CDI".

3. **Rate Increase History.** In a single table, provide for each product the amounts and dates of past rate increases implemented since the product was first marketed, and whether the product is now open or closed. Note any change in benefits.

Response: Please see the "Question 3-Rates" and "Question 3-Benefits" tabs in the accompanying document, "Jul-11 POS Data for CDI".

4. **Intent to File for Future Rate Increases.** When does the company intend to file for its next round of rate increases for small group policies?

Response:
KPIC intends to next file small group rates 60 days prior to January 1, 2012 for new and renewing groups effective on or after January 1 2012. Please note that Groups retain their rates for a period of 12 months.

5. **Filed Rate Changes.** For each product, provide the average, minimum and maximum tabular rate changes proposed:

a. For the current filings

Response:

Average weighted by member premiums	7.1%
Average weighted by member counts	7.6%
Minimum	1.9%

Maximum	10.2%

b. For all filings cumulatively during the twelve-month period ending with the next renewal date, according to the policies' anniversary dates.

Response:

Average weighted by member premiums	12.0%
Average weighted by member counts	12.5%
Minimum	6.1%
Maximum	14.8%

6. Rate Caps. Describe the action of rate caps, if any.

Response:
Currently, KPIC restricts RAF changes by five percentage points. This implies that the maximum RAF increase for a group is 5.6% (when RAF changes from 0.90 to 0.95).
Thus, the maximum rate increase a subscriber can get at renewal is 21.2% (please see Response to 5b). This number does not reflect rate changes related to demographic changes (a subscriber moving in the next age band or a change in a family composition.)

7. Development of Annual Rate Increase Percentage

a. Provide membership, earned premium and incurred claims data from CY 2008 and 2009, if available.

Response: please see the following table.

CY	Member Months	Earned Premium	Incurred Claims	MLR (Unadj.)
2009	16,189	8,214,749	8,088,896	98.5%
2010	14,261	8,094,271	11,304,921	139.7%

Note: Tier 1 network of the POS product is an integrated delivery system administered by KFHP. In the past, the financial results for the care provided within the integrated system for specific business lines were reported on consolidated basis, for the Health Plan (i.e. KFHP proper) and the Kaiser Foundation Hospitals company (KFH) combined. To address the ACA requirements, a new series of reports was created reflecting the Plan experience only. However, due to the fact that the past KFHP and KFH experiences cannot be easily separated, these reports do not go back beyond 2009. Thus, the requested POS data are not available for 2008. In the future, we will be providing the experience for three years as requested.

b. According the memorandum of the independent actuary, "the experience data is not credible enough to develop premium rates." This statement implies that the rates were developed on the basis of one or more other credible data sources.

i. Describe the source and the reasons for choosing the credible data sources.

ii. Show the development of the requested rate increases based on those credible data sources.

Response:

The experience data are accurate. However, the low membership for the product means that the experience data are not fully credible for purposes of rate making; that is, reliance on the experience period alone does not support the development of reliable projections.

Our goal when choosing the Jul-11 rate increase was to account for the medical trend, reduce the multi-year financial losses KPIC and KFHP have been experiencing on this product and keep the increase reasonably close to the 10.7% increase for the HMO products next to which the POS product is sold. Based on these considerations, the 12.0% rate increase was chosen.

8. Annual Rate (from the California Rate Filing Form Item #10**):** Provide an exhibit showing the percent change from current rate to proposed rate for each cell.

Response: Tab "Question 8" of the accompanying Excel worksheet displays the proposed 6-month (new business) and 12-month (renewal) rate increases by plan and geographic area. The increases are the same for all rating cells.

9. Annual rate increase distribution by employer: Create four or more bands according to the size of the employer's rate increase. Indicate the number of groups and members in each band.

Response:
Distribution of small groups and members renewing in Jul-11 to Dec-11 by rate increase is shown in the table below. The variation of the increases is a result of geographic factor changes described in the answer to Question 12. For specific group and member, RAF changes and demographic changes may result in higher or lower rate increases than shown in the table.

Group Counts	Member Counts	Jul-11 over Jul-10
5	11	6.1%
2	9	7.2%
76	247	11.7%
31	72	12.8%
41	126	14.8%

10. Enrollment summary. Provide total monthly member enrollment of all small group policies (including policies not covered by this filing) from 1/2006 forward by closed block and open block. Show separately enrollment for policies under the supervision of DMHC. Show historical sales and lapses.

Response:
Please see the "Question 10" tab in the accompanying Excel worksheet. POS and PPO (including an OOA Indemnity plan) are the only two KPIC small group products regulated by CDI. DMHC regulates Tier 1 of POS (the HMO network.) There are no separate policies for this tier. Also, please note that the first small group PPO plan was introduced in Jun-06.

The historical sales and lapses data is not available as it is still being researched and will be provided at a later date**.**

11. Risk Adjustment Factor. Describe the process by which risk adjustment factors are computed for renewing groups. Show the changes to average RAF over the past four quarters.

Response:

The following RAF values are used: 0.90, 0.95, 1.00, 1.05 and 1.10. All groups with less than six subscribers enrolled with either KFHP or KPIC, receive a RAF of 1.10. For a larger renewing group, the RAF is based on the average risk score generated for all KFHP and KPIC members (including HMO, POS and PPO enrollees) of the group by the drug-utilization version of the predictive DxCG model. Depending on the average risk score, the group's RAF may remain unchanged, decrease by five points or increase by five points.

The average RAFs for the groups with POS members were as follows:

Q2 2010	Q3 2010	Q4 2010	Q1 2011
1.02	1.02	1.01	1.01

As mentioned above, RAFs are calculated for all KFHP and KPIC members of the group and are not HMO, POS or PPO specific. The overall average small group RAF has remained stable for many years fluctuating in a very narrow interval around 1.00.

12. Impact of Area Definition Change. Describe the impact of this change on rates. Is it separate from or included in the requested rate increase?

Response:
In Jan-11, the geographic factor for the Sacramento area was reduced from 1.00 to 0.95. As a result, the proposed rate increase for the Sacramento groups renewing between Jul-11 and Dec-11 will be 4.3 percentage points lower, while the increase for all other Northern California groups will be 0.75 points higher than the average increase for Northern California.

In Jul-11, the geographic factor for Kern County was reduced from 1.00 to 0.95, while the factor for Orange County was increased from 0.90 to 0.925. As a result, between Jul-11 and Dec-11 the proposed 6-month (new business) and 12-month (renewal) rate increases will be 5.25 percentage points lower in Kern, 2.5 points higher in Orange and 0.25 points lower in the rest of Southern California than the average increases for the region.

The increases displayed on tab "Question 8" of the accompanying Excel worksheet as well as the average rate increases reported in this filing reflect all these adjustments.

13. Co-pays. Indicate whether office co-pays are included in the out-of-pocket maximum.

Response:
Office Visit copayments do not contribute towards satisfaction of the Out-of-Pocket Maximum under the POS plans.

14. Medical Loss Ratio per PPACA. The Department requires a Medical Loss Ratio (MLR) exhibit according to the guidance issued by the Department of Health and Human Services (HHS) on 11/18/2010. The MLR exhibit should show *by month* actual 2010 experience and the prospective experience in 2011 of the market segment relevant to plans being filed (i.e., *all small-group plans*, including those not included in the current filing). Experience includes breakouts by enrollment, incurred claims and earned premium. Breakouts should also be by open block and closed block. All small-group plans will be aggregated for the purposes of MLR calculation, and the MLR will be calculated in accordance with the HHS regulation.

Response:
The requested values are not available. The Tier 1 network of the POS product features Kaiser Foundation Health Plan (KPFH) providers and is administered by KFHP. KFHP is an integrated delivery system, which does not report experience data on monthly basis. Also, due to the small volume of experience, monthly MLR projections would be inherently unreliable.

The POS and PPO plans included in the respective filings constitute KPIC's entire small business block in California. However, we expect that the POS experience will be reported as part of KFHP's small business results, which is permissible under HHS guidance.

15. Additional information required per Guidance 1163:2. Note that the final version of Guidance 1163:2 was released on April 5, 2011. Provide the following per Section A of the Guidance: the nature and amount of transactions between the filing insurer and any affiliates over the prior three years.

Response:

The Company provides and purchases services from its affiliates in the ordinary course of business. Revenue is received related to administrative services provided under ASO agreements with affiliates, necessary to the operation of the affiliates' self-funded health benefit plans for their employees. The Company also provides stop loss coverage for certain of its affiliate's employee benefits.

The Company pays affiliates for administrative and professional support services, such as underwriting, marketing, sales, advertising, premium billing, collections, utilization management, case management, claims administration, actuarial, legal, occupancy, information technology, tax reporting and bank management. Additionally, the Company pays claims related to the stop loss coverage provided and purchases services from affiliates critical to its ASO business.

Revenue received and expensed paid to affiliates for these services for 2010, 2009 and 2008 are summarized below:

(Amounts in Thousands)		2010		2009		2008
REVENUE:						
ASO Revenue	$	41,573		21,044	$	955
Stop Loss Coverage Revenue		383		266		260
EXPENSES:						
Administrative Support Services	$	5,602		5,626	$	4,533
Professional Support Services		2,052		926		1,043
ASO Related Services		33,668		19,005		729
Stop Loss Related Claims		206		86		-

16. Additional information required per Guidance 1163:2. Provide the following per Section A of the Guidance for: Kaiser Permanente Insurance Company, its California health business, and the Small Group medical block in California

a. For 2008, 2009 and 2010: the post-tax statutory net income, statutory capital and surplus, and RBC authorized control level according to the Annual Statement of the Kaiser Permanente Insurance Company.

(Amounts in Thousands)		2010		2009		2008
Post-tax Statutory Net Income	$	3,839	$	1,577	$	3,506
Statutory Capital & Surplus		65,892		60,069		58,346
RBC Authorized Control Level		8,841		7,404		7,025

b. The anticipated post-tax statutory net income, statutory capital and surplus, and RBC authorized control level anticipated for the company in 2011.]

(Amounts in Thousands)		**2011**
Post-tax Statutory Net Income	$	3,268
Statutory Capital & Surplus		70,496
RBC Authorized Control Level		9,782

c. The company's dividend history, if applicable

Response:

a. For 2008, 2009 and 2010: the post-tax statutory net income, statutory capital and surplus, and RBC authorized control level according to the Annual Statement of the Kaiser Permanente Insurance Company.

c. The company's dividend history, if applicable. **Not Applicable**

17. Additional information required per Guidance 1163:2. Provide the following per Section A of the Guidance:

a. The annual compensation of each of the 10 most highly paid executives of both the insurer submitting the rate filing and the parent corporation / ultimate controlling party of that insurer.

Response:
The annual compensation data will be provided at a later date as the Department advised in its email of 6-10-11.

18. Additional information required per Guidance 1163:2. The California Plain Language Rate Filing Description requires cost information as a percentage of Medicare. Your filings indicate that this information is not available. Please provide justification as to why it is not available.

Response:
The calculation of cost as a percentage of Medicare pre-supposes fee for service reimbursement. Most care for the POS product is delivered in Tier 1, which features KFHP providers who are not compensated on a fee for service basis. Accordingly, the requested values are not available.

In addition, we note that:

- The POS product has three tiers (including Tier 3 which offers access to non-contracted providers); costs as a percentage of Medicare likely varies by Tier;
- Neither KFHP nor KPIC maintains a Medicare fee schedule;
- There are in fact many Medicare fee schedules;
- The request is especially problematic for facility services. The Medicare fee schedule for inpatient care is based on DRGs which vary by facility. In contrast, many commercial contracts use per diem or other reimbursement methods.

19. Actuarial Memorandum from the Independent Actuary: Format and Contents

a. The cover pages of the two actuarial memoranda should clearly identify their contents. Resubmit with the State Tracking Number on the cover page.

b. Per Guidance 1163:2 (20)(B)(4), the actuarial memoranda should address the factors listed in Section A of the Guidance. The memorandum pertaining to PF-2011-00828 satisfies this requirement; the memorandum pertaining to PF-2011-00829 does not. Revise the latter memorandum accordingly. When referring to a specific factor listed in Section A, reference its item number.

Response: the POS memorandum has been revised, both memoranda have been refilled.